PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

# ACCIDENT COVER
## CLAIM FORM

000148

**Before you give us your personal information please note that Irish Life has a Data Privacy Notice. This explains what your data protection rights are and how and why we use your personal information. This is always available on our website at www.irishlife.ie or you can ask us for a copy.**

In order for us to consider your claim, we require the following:

- **Section A:** Must be fully completed by you
- **Section B:** Must be fully completed by claimant's GP
- **Section C:**
  - If you are an employee part 1 must be fully completed by your employer
  - If you are self employed part 2 must be fully completed by you
  - If you are unemployed part 3 must be fully completed by you
- **All sections of the claim form must be signed & dated**

Please note we will not be able to assess your claim without all of the above.

**This claim form must be returned within two weeks of us posting it to you.**
**If there is a delay in returning this claim form we may not be in a position to consider your claim.**

We need relevant personal health information to assess this claim. We may need to contact you if we need to clarify any information or ask you for further information. We may also need to get relevant personal health information in connection with this claim from GPs, consultants, hospitals or other health professionals. We may use the health information obtained at this claim for any subsequent claims and/or applications to Irish Life.

In certain circumstances we will use the service of Private Investigators. Each Private Investigator must adhere to a strict code of practice and complete a compliance certificate. They are expected to comply at all times with the Data Protection Law and not perform their functions in such a way as to cause Irish Life to breach any of its obligations under the Data Protection Law. Any unauthorised processing, use or disclosure of personal data by Private Investigators is strictly prohibited.

When we receive your claim form we will start the assessment process. This process typically involves the following tasks:

1. Verifying the injury sustained and the circumstances of your accident
   - we may request reports from doctors and specialists you have attended
   - we may request an independent medical examination
   - we may arrange for someone to visit you at home
2. Determining how long you will be unable to carry out your job
   - this assessment will be made by our Chief Medical Officer or other relevant health professionals
3. Calculating your weekly benefit based on your earnings
   - The maximum amount you can receive is 40% of your weekly earnings
   - Proof of your earnings is required (refer to section C)

We will keep you informed if any further information is needed

If you have any questions regarding this claim form or your benefits, you can contact our Protection Claims Team or our Customer Service Team.

**Protection Claims Team**

Phone: (01) 704 1855
Monday – Friday 9am – 5pm

Fax: (01) 680 3387
Email: protectionclaims@irishlife.ie

**Customer Service Team**

(01) 704 1010
Monday – Thursday 8am – 8pm
Friday 10am – 6pm
Saturday 9am – 1pm
(01) 704 1900
protection@irishlife.ie

In the interest of customer service we will record and monitor calls.

**Send your claim form to:**
Protection Claims Team
Irish Life Assurance plc
Lower Abbey St
Dublin 1

Please note that the issuing of this claim form is not an admission of liability for a claim.

# Section A – To be completed by the claimant

## Claimant Details

Name of Claimant

Plan number

Address

Date of Birth d d / m m / y y y y

Occupation

Phone Number(s) Home Mobile

Email

Gross earnings in the year before the accident €

Amount of weekly sick pay €

Name of GP

Address of GP

## Accident Details

1. Date of accident d d / m m / y y y y Time of accident
2. Place of accident
3. What were the circumstances of the accident, i.e. what were you doing at the time the injury was sustained?
4. How was your injury sustained?
5. What was the exact nature of the injuries sustained?
6. Date of any period of hospitalisation (From – To, Name of Hospital)
7. What investigations did you undergo?
8. What treatment did you initially receive?

9. What date did you stop working? d d / m m / y y y y

10. How are you physically limited in your daily life?

| Following accident | Currently |
|---|---|
| | |
| | |
| | |
| | |
| | |

11. Specifically, what part of your job are you physically unable to do as a result of your injury?

12. How have your symptoms improved since the date of your accident? Please provide details of the progress of your recovery.

13. What treatment are you currently taking?

14. What advice has your doctor given to you regarding returning to work?

15. When do you anticipate that you will be able to return to work? d d / m m / y y y y
Please give details of the factors that are influencing the date you will return to work.

16. Since your disability began, have you undertaken any duties of your normal occupation?

17. Since your disability began, have you undertaken any other work (paid or unpaid)? Yes ◯ No ◯

18. Are you insured against accident, sickness or disability with any other insurance company? (e.g. income protection insurance) If yes, please provide full details

19. Have you ever suffered any illness in the past for which you have required medical advice or treatment?

Yes ◯ No ◯ If Yes, please give details

20. Please provide the names and addresses of all doctors and specialists you have attended in relation to your injury

21. Please provide dates for all appointments you have attended and details of any upcoming appointments

## Payment

In the event that your claim is admitted we can arrange for payment to be made in a number of ways. Please choose how you wish the claim to be paid by ticking the appropriate box:

1. If you wish to receive your payment by cheque please tick here ◯
2. If you are currently paying your plan by direct debit and would like payment to be made to this bank account, please tick here ◯
3. If you would like your payment to be made to another bank account in your name, please complete the section below and enclose a copy of a recent bank statement dated within the last 6 months. This statement should be for the account you wish payment to be made into and contain your name, address, BIC and IBAN and you should return it with this claim form. ◯

Bank Identifier Code (BIC)

IBAN

Account Name:

Bank Name & Address:

Your BIC and IBAN details can be found on your bank statement. You can also request them directly from your bank.

Important: Please note that the bank account details provided must be your own bank account or an account held jointly by you. Payment cannot be made to a third party or a third party bank account.

I/We wish to have our claim proceeds paid as above

Please sign and date

Your Signature ✗ Date d d / m m / y y y y

Joint Signature ✗ Date d d / m m / y y y y

Plan owner's Signature ✗ Date d d / m m / y y y y

## Declaration

I declare that all answers given by me in this statement are, to the best of my knowledge and belief, true and complete and that I am the person referred to in the particulars given.

I understand and agree that my claim with Irish Life Assurance plc (Irish Life) will be based on all personal and health information Irish Life hold from my applications and all personal and health information received for any claim.

I understand that if I provide false or deliberately inaccurate information on this form my cover may be cancelled.

I fully understand that I must notify Irish Life immediately if I resume my normal occupation either on a full time or part time basis, or if I take up alternative work whether paid or not, as failure to do so will result in my claim being rejected or payments being terminated and cover ceasing

Please sign and date

Signed ✗ Date d d / m m / y y y y

## Authorisation

I authorise Irish Life to request and receive my personal health information from any GPs, consultants, hospitals or other health professionals who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of assessing my claim.

Please sign and date

Signed ✗ Date d d / m m / y y y y

## Check List

**Fully completed claim form:**

- Section A fully completed by the claimant, signed and dated ◯
- Section B fully completed by the claimant's doctor signed, dated and stamped ◯
- Section C
  - If you are an employee part 1 must be fully completed by your employer ◯
  - If you are self employed part 2 must be fully completed by you ◯
  - If you are unemployed part 3 must be fully completed by you ◯
- Copy of most recent P60 if employed ◯
- Copies of accounts, tax computations and income tax assessment for the last full tax year.if self employed ◯
- Recent bank statement should you wish for the claim to be paid to an account other than the billing account (see above) ◯

# Section B – to be completed by claimant's GP

## Claimant Details

Name of Claimant

Occupation

How long have you been the claimant's medical attendant?

## Accident Details

1. Date of accident d d / m m / y y y y
2. Date of first consultation d d / m m / y y y y
3. Circumstances of the accident

4. Exact nature of injuries sustained

5. Please provide details of all investigations carried out:

| Test | Result | Date |
|---|---|---|
| | | dd / mm / yyyy |
| | | dd / mm / yyyy |
| | | dd / mm / yyyy |
| | | dd / mm / yyyy |

*Please provide copies of all results if available.*

6. On what date did incapacity commence? d d / m m / y y y y

7. Initially, what were the physical symptoms preventing the claimant from working?

8. What treatment was initially provided? Please include details of medication, physical aids, physiotherapy and surgery carried out.

9. Is the claimant fit for work now? Yes ◯ No ◯ If Yes, from what date? d d / m m / y y y y

10. Was the total duration of incapacity reasonable for this injury? Please give reasons for your answer.

## Ongoing incapacity details

11. Currently, what is causing the claimant's incapacity?

12. Currently, what aspects of the claimant's occupation are they unable to carry out as a result of their injury?

13. Please provide details of any improvements or deterioration since the date incapacity commenced.

14. Has the claimant consulted a specialist with their injury, if so, please give details:

| Name | Date | Outcome |
|---|---|---|
| | dd / mm / yyyy | |
| | dd / mm / yyyy | |
| | dd / mm / yyyy | |
| | dd / mm / yyyy | |

*Please provide copies of all results if available.*

15. Please provide exact details of current treatment. Please include details of medication, physical aids, and physiotherapy.

16. Is this treatment providing relief of symptoms? Yes ◯ No ◯

17. If the treatment is not providing relief, can you outline why?

18. Is a change of treatment being considered? Yes ◯ No ◯

    If Yes, when do you expect this to commence? d d / m m / y y y y

    What outcome would you anticipate from this new treatment?

19. When do you expect the claimant to be fit for work? d d / m m / y y y y

20. If the return to work date is unknown, how long do you expect the duration of incapacity to be (from today):

Short term (1-2 months) ◯

Medium term (3-6 months) ◯

Long term (6+ months) ◯

21. Is the duration of incapacity reasonable for this injury? Yes ◯ No ◯

Please give reasons for your answer

22. Is the claimant still attending you? Yes ◯ No ◯

23. Please give the date you last saw the claimant regarding the injury. d d / m m / y y y y

24. Is a further review planned? Yes ◯ No ◯

25. Has the claimant previously suffered from similar symptoms or injury? Yes ◯ No ◯

If yes, please provide details

26. Are you aware of any other medical history, medication, investigations or specialist treatment the claimant had prior to attending you? Yes ◯ No ◯

If yes, please provide details

Please sign and date

I certify that I have personally examined the claimant and that all foregoing statements are correct.

Signed ✗ Date d d / m m / y y y y

Name (BLOCK LETTERS)

Qualifications

Address

Contact number

Doctor's stamp

# Section C – Employment Details

## 1. If employed – Please have your employer complete the following:

Name of employer

Nature of business

Name of employee

Date employment commenced d d / m m / y y y y  Date last worked d d / m m / y y y y

Reason for stopping work on this date

What is their precise occupation?

Is the employee due to return to work? Yes ◯ No ◯

Please describe the main duties of their occupation

**Please enclose a copy of the employees most recent P60.**

Please sign and date

Signed ✗  Stamped

Company Number:  VAT Number:

**We cannot consider payment without evidence of earnings as outlined above.**

## 2. If self employed – please complete the following:

Please describe the exact nature of your business

Please describe the main duties of your occupation

Please provide details on how your incapacity from your work impact on your business (e.g. loss of profit, employing extra staff)

**Please enclose copies of accounts, tax computations and income tax assessment for the last full tax year.**

Please sign and date

Signed ✗  Stamped

Company Number:  VAT Number:

**We cannot consider payment without evidence of earnings as outlined above.**

## 3. If unemployed – please complete the following:

What date did you become unemployed? d d / m m / y y y y

What was your occupation prior to becoming unemployed?

Please describe the main duties of your previous occupation

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